DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 10/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 28, 2010 through October 12, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred and eleven (111). The survey sample totaled forty two (42) residents.	F 000	F278 Center administration accepts this finding without dispute. F279 Develop Comprehensive Careplans Resident's R 156, 157, and 177 no longer reside at the center. Resident R8 has been reviewed by the ICP team and the plan of care has been updated to reflect the resident's current level of care. Current resident's plans of care shall be reviewed with their next scheduled care conference and the plans of care shall be updated as necessary to reflect the residents current level of care.	12/1/2010
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	In-servicing shall be held for licensed nursing staff on or before12/1/2010, on the facility care plan policy. Random audits shall be completed over the next 90 days to determine compliance with accurate resident care plans; this shall be the responsibility of the DON/designee. Continued →	12/1/2010 12/1/2010 12/1/2010 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela "Lou" | TITLE: Administrator | (X6) DATE: 11/5/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Based on record review and interview it was determined that for four (R157, R177, R8 and R156) out of 42 sampled residents the facility failed to develop a care plan for an identified need. Findings include: 1. R157 was admitted to the facility on 4/29/10 with a stage II pressure ulcer to the sacrum. The initial MDS, dated 5/6/10, stated the presence of the pressure ulcer and approaches that were in place. The RAP summary sheet stated that the pressure ulcer was to be addressed in the care plan. Review of the medical record lacked evidence of a care plan addressing the pressure ulcer. An interview with the DON (E2), on 10/11/10, confirmed there was not a care plan to address the pressure ulcer. 2. R177 was admitted to the facility on 8/5/10 with stage one pressure ulcers according to the interagency form from the hospital. Review of R177's care plans with E4 (Unit manager), on 10/11/10 at 2:26 PM, confirmed the facility failed to develop a care plan for R177's pressure ulcers. 3. Review of R8's care plan for pain "Resident exhibits or is at risk for alteration in comfort related to chronic pain/shoulder dislocation" revealed the facility failed to identify the resident's need to hold her arm during care to prevent pain. Review of the CNAs documentation sheets and R8's care plan with E11 (CNA), E13 (LPN) and E12 (RN Unit Manager), on 10/8/10 at 9:30 AM, confirmed that R8's care plan failed to identify as an intervention that R8 had less left arm pain with care if the staff allowed her to navigate her left arm instead of the staff navigating it for her.	F 279	F279 Develop Comprehensive Careplans → Continued The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 ongoing

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F 279	Continued From page 2 4. R156 was admitted to the facility on 8/23/10. The MDS assessment, dated 9/2/10, documented that R156 exhibited mood and behavior symptoms of crying, tearfulness and insomnia/change in regular sleep pattern up to five times a week. Record review lacked evidence of a care plan addressing these changes in mood and behavior symptoms. An interview with E3 (Assistant Director of Nursing), on 10/11/10 at approximately 11 AM, confirmed that there was not a care plan for these behavior symptoms.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	F280 Right to participate planning care-revise careplan. Resident's R10, 35, and 44 remain in the center and have had their care plans revised to reflect their current level of care. They have been reviewed by the ICP team to review their current level of care. Current residents shall have their plans of care reviewed at their next scheduled review to determine compliance with appropriate intervention. Current residents care plans shall be revised with changes in condition In-servicing shall be held for licensed nursing staff on or before 12/1/2010 on the center care plan policy. Continued →	12/1/2010 12/1/2010

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F 280	Continued From page 3 Based on record review and interview it was determined that for three (R35, R10 and R44) out of 42 sampled residents the facility failed to revise care plans when there were changes in residents' needs. Findings include: 1. R35's care plan for "distressed mood symptoms exhibited as anxiety" included the approach to offer medication for anxiousness as needed. The resident did not have a physician's order for PRN (as needed) anxiety medication. This was confirmed by staff interview on 10/12/10 with E2 (DON). 2. R10's care plan included an identified need of "Resident is at risk for complications related to the use of the psychotropic medication Seroquel". The resident had no current physician order for Seroquel or any other psychotropic medication. Review of the record and confirmation by the nurse E5 revealed that Seroquel had been discontinued on 2/26/10. 3. The 6/4/10 quarterly MDS for R44, who had a diagnosis of dementia, indicated that she was coded as a 1, supervision, for dressing herself and coded a 2, limited assistance, for personal hygiene. The 9/4/10 quarterly MDS for this resident indicated that she was coded as a 3, extensive assistance, for dressing herself and personal hygiene, respectively. The ADL care plan for this resident, that was in place prior to the 6/4/10 MDS, was unchanged as of 10/5/10. No goals or interventions were changed to address the change in status of the resident captured on the MDS for the time frame. Interview with nurse E5, on 10/5/10 @ 15:30, indicated that the resident was dressing herself	F 280	F280 Right to participate planning care-revise careplan. → Continued. Random audits shall be completed over the next 90 days via the 24 hour report to determine compliance with care plan updates; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 ongoing 12/1/2010 ongoing

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F 280	Continued From page 4 during the June, 2010 time period. Staff began to notice, over time, that the resident had body odors and realized that her cognitive status was interfering with her ability to properly self-dress and perform self-hygiene. Staff on this resident's unit knew of the new needs for this resident but the care plan had not been updated. Interview with E17, C.N.A., on 10/1/10, indicated that the ADL needs for this resident were being addressed and that she was charting the information on the electronic monitoring system to reflect the new care needs.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, it was determined that the facility failed to provide the necessary care and services pertaining to pain management for one (R217) of 42 sampled residents. R217 had experienced pain of lower back with radiation down the left leg and the facility failed to reassess and monitor the effectiveness of R217's pain management interventions. Findings include: R217 admitted to the facility on 9/27/10 with diagnoses including cauda equina syndrome (a rare disorder affecting the bundle of nerve roots	F 309	F309 Provide Care/Services for highest well being Resident R217 has been reviewed by the ICP team and has been assessed for an acceptable level of pain relief. The plan of care has been up dated to reflect any necessary changes in the resident's level of care. The primary care physician has reviewed current pain medications to meet the acceptable pain goal. The resident is assessed every shift to determine adequate pain relief from the routine pain medications and the 1-10 scale is used for PRN pain medications. Current residents have been reviewed for their acceptable level of pain and appropriate pain management. Current residents will be assessed every shift for pain relief from routine pain medications. Continued →	12/1/2010

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F 309	Continued From page 5 at the lower end of the spinal cord, is a surgical emergency; American Association of Orthopaedic Surgeons), status post lumbar spine fusion (performed on 9/8/10), lumbar spine laminectomy (performed on 8/31/10), and hypertension. Pain evaluation, dated 9/28/10, indicated that within the past five days, R217 had experienced moderate level of pain in the lower back with radiation down the left leg and rated the pain at "6" on a scale of "0" no pain to "10" to excruciating pain. Review of care plan for alteration in comfort, dated 9/28/10, included a goal that the resident would achieve an acceptable level of pain control. Interventions included: - Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. - Utilize pain scale. - Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated. The facility policy titled "Pain Management" stated that the purpose was "to design a plan of care to achieve an optimal balance between pain relief and preservation of function in accordance with patient directed goals." In addition, the practice standard included that "patient receiving interventions for pain will be monitored for effectiveness in providing pain relief." Review of progress note, dated 9/28/10 timed 2:43 PM, documented that R217's attending physician was contacted and that new pain medication orders were received for Oxycontin (controlled release narcotic pain medication to treat moderate to severe pain) 20 mg (milligram) twice a day and Oxycodone (narcotic pain	F 309	F309 Provide Care/Services for highest well being → Continued… In-servicing will be completed by 12/1/2010 for licensed nursing staff on pain management, acceptable levels of pain, and pain scale. Random audits shall be completed over the next 90 days via the 24 hour report to determine compliance with pain management protocols; this shall be the responsibility of the DON/designee. The DON shall report to the administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing

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F 309	Continued From page 6 medication to treat moderate to moderately severe pain) 5/325 mg by mouth every four hours as needed for breakthrough pain. Review of R217's September 2010 MAR (Medication Administration Record) from 9/28/10 through 9/30/10 revealed that R217 was administered Oxycontin 20 mg twice a day at 8 AM and 5 PM routinely for total of five doses. Neither the MAR or the nurses notes indicated that the nurses assessed the pain characteristics including quality, severity, and location of the pain prior to and after the administration of new routine pain medication, Oxycontin 20 mg. Interviews were conducted during the survey with three staff nurses (E14, E15, and E16) who administered the routine Oxycontin to R217 during September 2010. The interviews revealed that the current facility system did not require that the nurses assess the pain characteristics for routine pain medication. Review of R217's "Pain Observation and Management Flowsheet" from 9/28/10 through 9/30/10 documented with each administration of the 'as needed' Oxycodone 5/325 mg for back pain, the nurses documented the pain severity prior to medication administration as "8" and level of pain one hour after pain medication as "0". Interview with E2 (DON), on 10/5/10 at approximately 11:30 PM, revealed that the current facility system included, for routine pain medication, that the nurses would assess the pain prior to and after routine pain medication and document assessment in the nurses notes. In addition, 'as needed' pain medication was to be documented on the "Pain Observation and	F 309	LEFT BLANK INTENTIONALLY	

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F 309	Continued From page 7 Management Flowsheet." Subsequent to this interview, review of the September 2010 nurses notes lacked evidence of assessment of pain when the routine Oxycontin was administered. The following pain management standards were approved by the American Geriatrics Society in April 2002 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Due to the above failures, the facility failed to objectively determine the effectiveness of the administered pain medication consistent with the current standards of practice. In addition, the facility failed to develop a pain management program to include R217's goal for pain control. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 10/12/10 at approximately 1 PM.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 Treatment/Services to Prevent/Heal Pressure Ulcers Resident R219 remains in the center. The resident's wounds are measured weekly. Treatments are preformed using aseptic technique. Current residents have been reviewed to determine completion of measurements and the use of aseptic technique for wound care. Continued →	12/1/2010

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F 314	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R219) out of 42 sampled residents the facility failed to ensure proper technique was used during a treatment to prevent infection. The facility failed to ensure wounds were assessed and measured weekly according to the care plan and current professional standards. Findings include: 1a. On 10/1/10 at 1:29 PM, a pressure sore treatment observation was conducted on R219 by E8 (wound nurse). After removing the old dressing, the nurse removed her gloves and washed her hands. The nurse went to the treatment cart to get more supplies. In the process she touched her keys, the cart, the treatment product, dropped a glove and picked it up from floor and threw it away, touched the privacy curtain and proceeded to put new gloves on and cleansed the wound without cleansing her hands again. The facility's policy for aseptic dressing includes washing hands between setting up supplies and starting treatment. 1b. R219 was admitted on 9/13/10 with nine wounds (7 pressure and 2 stasis). Measurements were documented on all the wounds upon admission. The next measurements were not done until 9/23/10, 10 days later. The resident's care plan included the approach of measuring wounds weekly.	F 314	F314 Treatment/Services to Prevent/Heal Pressure Ulcers → Continued… In-servicing shall be complete for licensed nurses on or before 12/1/2010 on aseptic dressing changing and wound measurements. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance. F323 Free of Accident Hazards/Supervision/Devices Next page…	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	Continued →	

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F 323	Continued From page 9 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for two (R219 and R201) out of 42 sampled residents the facility failed to ensure medications being left in resident rooms did not pose an accident hazard for the resident or other vulnerable residents residing and/or wandering in the area. Findings include: 1. Observation on 10/1/10 at 9:15 AM noted R219 to be in her room with medication cups containing pills and liquid. The resident was taking one of the pills with applesauce. There was no nurse present in the room. The nurse E6 was noted to be administering medications three doors down. The resident's ordered medications for this medication pass were; Megace 800 mg, Sodium Bicarbonate 65 mg, MVI, Omeprazole 20 mg, Mylanta Gas 30 ml, Aspirin 81 mg, Cardizem CD 180 mg, Pepcid 20 mg, Ferrous Sulfate 325 mg, Mag-ox 400 mg 2 tablets. The facility's policy for medication administration directs the nurse to "observe the patient's consumption of the medication(s)". An interview with E6 on 10/12/10 at 10 AM revealed that the resident takes 30 to 40 minutes to take her medication and has to be encouraged to take the medications. An interview, on 10/12/10	F 323	F323 Free of Accident Hazards/Supervision/Devices → Continued… Resident R219 remains in the center. Resident R215 and R201 no longer reside at the center. Resident R 219 continues to receive medications with nursing supervision. Current residents have been reviewed to determine compliance with medication administration. In-servicing shall be completed for licensed nurses on or before 12/1/2010 on medication administration. Random audits shall be over the next 90 days to determine compliance with medication administration; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	12/1/2010 12/1/2010 12/1/2010 Ongoing 12/1/2010 Ongoing

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F 323	Continued From page 10 at 10:05 AM, with the DON, E2, revealed that R219 does not have a plan to self administer medication and should not have been left alone in her room to take her medication. 2. Observation on 10/4/10 at 10 AM noted R215 to be in her room with a medication cup containing two white pills on top of the bedside table. There was no nurse present in the room. An interview with E15 (the medication pass nurse for R215) at 10:05 AM on 10/4/10 revealed that E15 left the two Percocet (narcotic pain medication) tablets in the room since the resident was vomiting earlier at 8:30 AM. E15 confirmed that she failed to follow the facility policy and left the medication with the resident.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	F329 Drug regimen is free from unnecessary drugs. Resident's R29 and R156 no longer reside in the center. Resident R10, R20, R35, R45, R55, R147, and R156 remain in the center. The above residents have been reviewed by the ICP team and their plans of care have been reviewed changes have been made as necessary to reflect the residents current status. These residents have had behavior monitoring sheets put in place to monitor behaviors. The pharmacy consultant has been contacted to address the reduction of medications. Current residents receiving psychoactive medications have been reviewed and behavior tracking sheets have been put in place. Labs have been reviewed to determine that all have been completed as ordered. Continued →	12/1/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 10/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 329	Continued From page 11 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for eight (R35, R10, R29, R147, R55, R20, R156, and R45) out of 42 sampled residents the facility failed to ensure adequate monitoring of behaviors symptoms and side effects were maintained for the use of anxiety and psychotropic medications. R10's lipid profile was not monitored yearly as indicated by physician orders. Findings include: 1. R35 had a physician's order for Ativan 0.5 mg hs (at bedtime) for anxiety. The resident's care plan for risk for complications related to the use of psychotropic drugs included a goal of resident will have the smallest most effective dose without side effects x 100 days. Approaches included: gradual dose reduction as ordered, monitor for changes in mental status and functional level and report to MD as indicated, monitor for continued need of medication as related to behavior and mood, and monitor for side effects and consult physician and pharmacist as needed. The resident also had a care plan for resident exhibits distress mood symptoms as evidence by anxiety that included the approach of monitoring side effects of medication. Review of the record revealed that there was a blank behavior monitoring sheet. Review of the computer data completed by the aide lacked any behavior monitoring.	F 329	F329 Drug regimen is free from unnecessary drugs. → Continued… In-servicing shall be completed for licensed nurses on or before 12/1/2010 on behavior monitoring, and physician lab orders. Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee will assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing

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F 329	Continued From page 12 An interview with a 3-11 nurse, E7, on 10/4/10 at 3 PM, revealed that the resident had been on Ativan at night for at least the past two years. It was further revealed that staff was not documenting on the behavior monitoring sheet because the resident was no longer exhibiting any behaviors. E7 stated that the resident likes things done in a certain way at a certain time and if it does not happen her way she gets upset and anxious. Review of the physician progress notes and yearly history and physical lacked any information about the Ativan beyond its use for anxiety or insomnia. Review of the consultant pharmacist review lacked any evidence that Ativan was being addressed for monitoring or dose reduction. 2a. R10 had a physician's order for Ativan 1 mg bid at 8 am and 8 PM for bipolar / anxiety. The resident's care plan, dated 9/23/10, stated resident exhibits behavior, agitation as evidenced by increased pacing, increased episodes of medical and non-medical unfounded complaints, increased manic behavior. An interview with the staff nurse, E5 on 10/1/10 at 10:10 AM, revealed that the resident's anxiety presented with increased respiration, face turned red, voice became raspy, eyes bulged, she had a panicked look about her. She further revealed that the Ativan was originally ordered prn but it was not controlling her anxiety enough. The resident would get too anxious before she asked for the Ativan. E5 identified certain triggers that set R10 off like a doctor appointment, new staff, or time of medication administration. E5 stated that staff do a lot of preparation and teaching prior	F 329	LEFT BLANK INTENTIONALLY	

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F 329	Continued From page 13 to appointments and changes in schedule to help reduce the anxiety. E5 stated that R10 was a lot better on the twice a day Ativan. Observations of R10 on 10/4 and 10/10/10 noted the resident to be anxious about current health problems and testing. Review of the record and confirmation with staff E2 (DON) on 10/12/10 revealed that behaviors related to anxiety for R10 were not being documented by staff. On 10/1/10 behavior monitoring was started. 2b. R10 had a current order for Lipitor 40 mg hs for high cholesterol and Zetia 10 mg qd for high cholesterol. The physician ordered a lipid profile to be done every August. The last lipid profile on the medical record was 8/5/09. An interview with the direct care nurse, E5, revealed that there was not a lipid profile done in August. The pharmacist review conducted on 9/27/10 indicated that no lipid profile could be found for August 2010. The facility had the lipid profile done on 10/2/10. 3. R29 had a diagnosis of anxiety and had a physician's order for xanax 0.25 mg hs. The resident's care plan for distressed mood with a history of anxiety and depression, listed that the resident should express her feelings with staff x 100 days and that the resident should experience a restful night sleep by the next review period. Besides behavioral interventions; psychological consultation as needed, maintaining family/responsible party contacts, monitoring current medication regime, medicate resident per physician order (PRN) and monitor for effectiveness were listed on the care plan. When asked for behavior monitoring data, E15 (nurse)	F 329	LEFT BLANK INTENTIONALLY	

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F 329	Continued From page 14 referred to the care plan but had no monitoring data to delineate the targeted behavior to address the potential for dose reduction of a benzodiazapine. Review of the monthly pharmacy consultant records dated 3/19/10 indicated that a dose reduction was initiated for Sertraline (Zoloft) for this resident. Nothing in the monthly pharmacy consultant record from 1/1/10 to 9/30/10 addressed the reduction of the routine use of xanax for this resident. 4. R147 had a physician order dated 10/25/09 for Xanax 0.25 mg one tablet by mouth every 8 hours as needed for anxiety. Review of R147's MAR revealed she was administered the Xanax on June 24, 2010, July 3rd and 25th, 2010. R147 did not receive the Xanax in August or September 2010. Review of R147's clinical record and Point of Care revealed the facility failed to provide behavior monitoring for the use of the Xanax. Review of R147's care plan for "Anxiety" stated "resident does not like to take xanax as it gives her a hang over effect." Review of the care plan with E12 (RN Unit Manager), at 9:00 AM on 10/4/10, confirmed the facility failed to monitor R147's use of Xanax and it should have been discontinued. On 10/4/10 R147's Xanax was discontinued by the physician. 5. R55 had a physician order dated 6/12/10 for Seroquel U-D 25 mg one tablet by mouth twice daily. Review of R55's clinical record, including the CNA point of care documentation, revealed the facility failed to provide behavior monitoring for the use of the Seroquel for R55. Review of the information with E2 (DON), on 10/11/10 at 11:25	F 329	LEFT BLANK INTENTIONALLY	

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F 329	Continued From page 15 AM, confirmed the facility failed to monitor R55's use of the Seroquel. 6. Review of R20 's September 2010 monthly Physician's order Form (POF) documented an order for Librium (medication to manage anxiety) 5 mg by mouth twice a day for anxiety. Review of September 2010 MAR documented that R20 was administered the medication as ordered. Interview with E15 (staff nurse), on 10/11/10 at approximately 12:27 PM, revealed that the use of the above medication was related to R20's behavior symptom of physical aggression with care. In addition, E15 indicated that the licensed staff was not monitoring behavior and/or the potential side effects of routine medication utilized for such behavior symptoms. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 10/12/10 at approximately 1 PM. 7. Review of R156 ' s September 2010 monthly POF documented an order for Ativan (anti-anxiety medication) 0.5 mg by mouth every 12 hours as needed for anxiety. Review of September 2010 (MAR) documented that R156 was administered Ativan 0.5 mg by mouth 10 times. Record lacked evidence of a target behavioral symptom, the monitoring of the behavioral symptoms, and/or the potential side effects of the Ativan. An interview with E3 (ADON), on 10/11/10 at approximately 11 AM, revealed that beginning on 10/5/10, a Behavior Monitoring Flow Record was initiated for R156 noting a behavior symptom of anxiety as evidenced by increased need for	F 329	LEFT BLANK INTENTIONALLY	

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F 329	Continued From page 16 companionship to monitor this symptom. Findings were reviewed with E1 (Administrator) and E2 (Director of Nursing) on 10/12/10 at approximately 1 PM. 8. Review of R45's September 2010 monthly POF documented an order for Xanax (anti-anxiety medication) 0.25 mg by mouth at bedtime for anxiety and Xanax 0.25 mg by mouth every six hours as needed for anxiety. Review of September 2010 MAR documented that R45 was administered the daily bedtime Xanax as ordered. In addition, R45 was administered Xanax 0.25 mg as needed on 9/9/10 at 10:15 and the outcome of this pharmacological intervention as noted on the MAR was " helped little. " In addition, R45 was administered another dose on 9/28/10 at 10:45 PM which resulted in decreased symptoms and signs. The record lacked evidence of a target behavioral symptom, monitoring of the symptoms as well as the potential side effects. Findings reviewed with E1 (Administrator) and E2 (Director of Nursing) on 10/12/10 at approximately 1 PM.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 334	F334 Influenza and pneumococcal immunizations. Current and New residents are being reviewed for Pneumococcal immunizations. It is being determined if the resident received the immunization prior to admission, if not they will be offered the immunization at the center. In-servicing shall be completed for licensed nurses on or before 12/1/2010 on immunizations. Continued →	12/1/2010 12/1/2010

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F 334	Continued From page 17 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334	F334 Influenza and pneumococcal immunizations. → Continued… Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 ongoing 12/1/2010 ongoing

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F 334	Continued From page 18 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to determine the pneumococcal vaccination status of one resident (SSR1) out of five sampled residents. Findings include: SSR1 was admitted to the facility on 7/28/10. Record review lacked evidence that the facility offered the pneumococcal vaccination or determined whether the resident was immunized already. Interview with the E3 (ADON), on 9/30/10 at approximately 9 AM, confirmed that the facility did not have evidence of whether or not the resident previously was administered the pneumonia vaccination. During the survey, the resident was asked by the facility whether she had the pneumococcal vaccination and the resident indicated that she had received this vaccination in 2008.	F 334		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428	F428 Drug regimen review, report irregular, act on… Resident's R10, R29, R35, R45, and R147 remain in the center and has had behavior monitoring sheet put in place. Current residents on any psychoactive medications have also been place on behavior monitoring. The Pharmacy Consultant shall monitor residents on psychoactive medications for appropriate documentation monthly. Continued →	12/1/2010

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F 428	Continued From page 19 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for seven (R35, R10, R29, R147, R55, R45, R20) out of 42 sampled residents the consultant pharmacist failed to identify the lack of behavior symptom and side effect monitoring for the use of anxiety and psychotropic medications. Findings include: Cross refer F329 example #1. 1. Review of the pharmacist's monthly reports lacked evidence that the consultant pharmacist identified the lack of behavior and side effect monitoring for the use of Ativan every evening for R35's anxiety and insomnia. There was no evidence that the pharmacist made a recommendation to decrease or discontinue the use of this medication. Cross refer F329 example #2. 2. Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of ativan twice a day for R10's anxiety. There was also no evidence that the pharmacist made a recommendation to decrease or discontinue the	F 428	F428 Drug regimen review, report irregular, act on… → Continued… In-servicing shall be held for licensed nursing and pharmacy staff on or before 12/1/2010 on behavior monitoring. Audits shall be completed monthly by the Pharmacy consultant and randomly by the center over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing

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F 428	Continued From page 20 use of the medication. Cross refer F329 example #3. 3. Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of xanax, daily at bedtime for R29's anxiety. There was also no evidence that the pharmacist made a recommendation to decrease or discontinue the use of the medication. 4. Cross refer F329 example #4 Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of Xanax for R147's anxiety. There was also no evidence that the pharmacist made a recommendation to change or discontinue the use of the medication even after the care plan documented R147 did not like taking Xanax. 5. Cross refer F329 example #5 Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of Seroquel for R55. There was also no evidence that the pharmacist had identified that the facility failed to monitor the use or side effects of Seroquel for R55. Review of the pharmacy review sheets with E2 (DON) on 10/12/10 at 10:01 AM confirmed the pharmacist failed to identify that the facility did not have appropriate monitoring for the use of Xanax for R147 and the use of Seroquel for R55.	F 428	LEFT BLANK INTENTIONALLY	

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F 428	Continued From page 21 Cross refer F329 example #6. 6. Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of Librium 5 mg twice a day for R20's anxiety. Cross refer F329 example #8. 7. Review of the pharmacist's monthly review reports lacked evidence that the consultant pharmacist identified the lack of behavior monitoring to support the use of xanax 0.25 mg daily at bedtime and xanax 0.25 mg every six hours as needed for R45's anxiety.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F441 Infection control, prevent spread, linens… Routine infection control practices are being maintained in the center. In-servicing was completed for employee E14 on hand washing prior to the end of the survey. In-servicing shall be completed for center licensed nursing staff on or before 12/1/2010 on hand washing with medication administration. Random rounds shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee. The DON shall report to the administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing

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F 441	Continued From page 22 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide proper hand/finger washing before administering medications to one observed resident (R211) out of 42 sampled residents. Findings include: On 10/5/10 at 8:20 AM, during the medication administration observation, E14 (RN) was observed licking her fingers prior to changing the pages on the MAR for R211. E14 also licked her fingers when going through R211's blister packages of medications. E14 failed to wash her hands prior to administering medications to R211. Review of the incident with E14 confirmed she had a habit of licking her fingers to change pages and go through the blister packs of medications during her medication pass in the facility.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469	F469 Maintains effective pest control program Center administration has contacted the facility's pest control company to request a modification to the present pest control plan to more effectively address the issue of flying insects. The air curtain in the loading dock area will be modified to prevent disabling for convenience by staff. The facility's pest control agreement is being updated to include treatment of flies. Continued →	12/1/2010

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F 469	Continued From page 23 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on multiple observations throughout the building during the survey, it was determined that the facility failed to keep the building free of signs of insects. The facility's pest control agreement failed to include flies. Findings include: 1. Observations made 9/28 - 9/30/10 during stage I revealed flies in resident rooms on station 1 and 2. Several residents were noted to keep fly swatters within reach to kill flies. 2. During a treatment observation on 10/1/10, flies were observed around the treatment cart while the nurse was preparing the supplies and around the resident's (R219) bed during the treatment. 3. On 10/11/10 @ 14:25, one fly was observed in the hallway adjacent to the smoking area exit. This exit door had glue strips hanging outside and a ultraviolet light glue trap on the inside. These interventions did not block flies from entering the building through this frequently used doorway. 4. On 10/4/10 @ 11:00, the air curtain (an air blowing device to block flies) to the loading dock entrance, adjacent to the dietary dry goods storage area, had been turned off, making this delivery entrance accessible to flying insects. 5. Review of the facility's pest control service agreement dated 2/28/08 stated under services to	F 469	F469 Maintains effective pest control program → Continued… In-servicing shall be held for all employees regarding the importance of consistent use of the air curtain. Random rounds shall be completed to determine compliance with the use of the air curtain and control of the flies over the next 90 days; this shall be the responsibility of the Maintenance director/designee. The Maintenance director shall report to the Administer and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	12/1/2010 12/1/2010 ongoing 12/1/2010 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 10/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 469	Continued From page 24 be rendered for control of "roaches, rodents, ants and silverfish" treat entire facility for above pests. This agreement failed to include flies.	F 469	LEFT BLANK INTENTIONALLY	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085015	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 10/12/2010
NAME OF PROVIDER OR SUPPLIER: **SEAFORD CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE: **1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interview it was determined that the facility failed to accurately document assessments on the MDS (Minimum Data Set) for 3 (R177, R 61 and R69) out of 42 sampled residents. Findings include:

1. Review of R177's admission MDS, dated 5/5/10, revealed the facility documented two pressure ulcers for this resident. The pressure ulcers were described as one stage III and one stage IV. Review of the hospital interagency form revealed the hospital documented R177 had a stage one pressure ulcers. Review of the information with E4 (ADON/Unit Manager) and E10 (RN wound nurse) on 10/11/10 at 2:26 PM confirmed R177's MDS was inaccurately coded for pressure ulcers.

2. Review of R61's MDS, dated 9/13/10, revealed that R61 did not have any falls for the last 30 or last 180 days. Review of R61's clinical record revealed Nurses notes documented R61 fell on 1/6/10, 4/13/10 sat in floor in hallway, fell on 7/2/10, and fell on 7/16/10. Review of the information with E2 (DON) on 10/8/10 at 9:45 AM confirmed R61's MDS was inaccurately coded for falls.

3. Review of R42's 8/19 /10 MDS documented he demonstrated behaviors. Review of R42's clinical record revealed there was no assessment or documentation verifying R42 had behaviors. Review of R42's clinical record on 10/11/10 at 8:35 AM with E1 (DON), revealed the MDS for R42 was inaccurately coded for behaviors.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: October 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from September 28, 2010 through October 12, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was one hundred and eleven (111). The survey sample totaled forty-two (42) residents.	F279 Develop Comprehensive Careplans Resident's R 156, 157, and 177 no longer reside at the center. Resident R8 has been reviewed by the ICP team and the plan of care has been updated to reflect the resident's current level of care. Current resident's plans of care shall be reviewed with their next scheduled care conference and the plans of care shall be updated as necessary to reflect the residents current level of care. In-servicing shall be held for licensed nursing staff on or before12/1/2010, on the facility care plan policy. Random audits shall be completed over the next 90 days to determine compliance with accurate resident care plans; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. F280 Right to participate planning care-revise careplan. Resident's R10, 35, and 44 remain in the center and have had their care plans revised to reflect their current level of care. They have been reviewed by the ICP team to review their current level of care. Current residents shall have their plans of care reviewed at their next scheduled review to determine compliance with appropriate intervention. Current residents care plans shall be revised with changes in condition Continued →
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross refer to the CMS 2567-L survey report date completed 10/12/10, F278,	

Provider's Signature [signature] Title Administrator Date 11/5/2010

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NAME OF FACILITY: Seaford Center

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	F279, F280, F309, F314, F323, F329, F334, F428, F441, and F469.	F280 → Continued.... In-servicing shall be held for licensed nursing staff on or before 12/1/2010 on the center care plan policy. Random audits shall be completed over the next 90 days via the 24 hour report to determine compliance with care plan updates; this shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance. F309 Provide Care/Services for highest well being Resident R217 has been reviewed by the ICP team and has been assessed for an acceptable level of pain relief. The plan of care has been up dated to reflect any necessary changes in the resident's level of care. The primary care physician has reviewed current pain medications to meet the acceptable pain goal. The resident is assessed every shift to determine adequate pain relief from the routine pain medications and the 1-10 scale is used for PRN pain medications. Current residents have been reviewed for their acceptable level of pain and appropriate pain management. Current residents will be assessed every shift for pain relief from routine pain medications. In-servicing will be completed by 12/1/2010 for licensed nursing staff on pain management, acceptable levels of pain, and pain scale.

Continued →

F309 → Continued...
Random audits shall be completed over the next 90 days via the 24 hour report to determine compliance with pain management protocols; this shall be the responsibility of the DON/designee.

The DON shall report to the administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F314 Treatment/Services to Prevent/Heal Pressure Ulcers
Resident R219 remains in the center. The resident's wounds are measured weekly. Treatments are preformed using aseptic technique. Current residents have been reviewed to determine completion of measurements and the use of aseptic technique for wound care.

In-servicing shall be complete for licensed nurses on or before 12/1/2010 on aseptic dressing changing and wound measurements.

Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

F323 Free of Accident Hazards/Supervision/Devices
Resident R219 remains in the center. Resident R215 and R201 no longer reside at the center. Resident R 219 continues to receive medications with nursing supervision. Current residents have been reviewed to determine compliance with med administration.

In-servicing shall be completed for licensed nurses on or before 12/1/2010 on medication administration.

Random audits shall be over the next 90 days to determine compliance with medication administration; this shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

F329 Drug regimen is free from unnecessary drugs.
Resident's R29 and R156 no longer reside in the center. Resident R10, R20, R35, R45, R55, R147, and R156 remain in the center. The above residents have been reviewed by the ICP team and their plans of care have been reviewed changes have been made as necessary to reflect the residents current status. These residents have had behavior monitoring sheets put in place to monitor behaviors. The pharmacy consultant has been contacted to address the reduction of medications. Current residents receiving psychoactive medications have been reviewed and behavior tracking sheets have been put in place. Labs have been reviewed to determine that all have been completed as ordered.

Continued →

F329 → Continued
In-servicing shall be completed for licensed nurses on or before 12/1/2010 on behavior monitoring, and physician lab orders.

Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee will assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F334 Influenza and pneumococcal immunizations.
Current and New residents are being reviewed for Pneumococcal immunizations. It is being determined if the resident received the immunization prior to admission, if not they will be offered the immunization at the center.

In-servicing shall be completed for licensed nurses on or before 12/1/2010 on immunizations.

Random audits shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F428 Drug regimen review, report irregular, act on…
Resident's R10, R29, R35, R45, and R147 remain in the center and has had behavior monitoring sheet put in place. Current residents on any psychoactive medications have also been place on behavior monitoring. The Pharmacy Consultant shall monitor residents on psychoactive medications for appropriate documentation monthly.

In-servicing shall be held for licensed nursing and pharmacy staff on or before 12/1/2010 on behavior monitoring.

Audits shall be completed monthly by the Pharmacy consultant and randomly by the center over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.

The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F441 Infection control, prevent spread, linens…
Routine infection control practices are being maintained in the center.

In-servicing was completed for employee E14 on hand washing prior to the end of the survey. In-servicing shall be completed for center licensed nursing staff on or before 12/1/2010 on hand washing with medication administration.

Continued →

5 of 5
additional

F441 → Continued
Random rounds shall be completed over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee.

The DON shall report to the administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

F469 Maintains effective pest control program
Center administration has contacted the facility's pest control company to request a modification to the present pest control plan to more effectively address the issue of flying insects. The air curtain in the loading dock area will be modified to prevent disabling for convenience by staff. The facility's pest control agreement is being updated to include treatment of flies.

In-servicing shall be held for all employees regarding the importance of consistent use of the air curtain.

Random rounds shall be completed to determine compliance with the use of the air curtain and control of the flies over the next 90 days; this shall be the responsibility of the Maintenance director/designee.

The Maintenance director shall report to the Administer and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.